CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH
DRUG CONTROL & PROFESSIONAL PRACTICES BRANCH
275 EAST MAIN STREET
FRANKFORT 40621-0001

For Office Use Only
Lic. No._____
Date mailed_____

APPLICATION FOR NEW LICENSE AS MANUFACTURER OR WHOLESALER OF CONTROLLED SUBSTANCES

All licenses expire June 30 and are not transferable. Please type application and submit to the above address with check or money order made payable to the Kentucky State Treasurer in the amount of $240. 00.

1. The undersigned hereby makes application for a □ **Manufacturer's**, or □ **Wholesaler's** (Check Only One) Controlled Substance License under the provisions of KRS 218A,

   b. Schedule(s) □ II □ IIN □ III □ IIIN □ IV □ V (Check all that apply)

   c. □ 1,4 Butanediol, Gamma-Butyrolactone, GBL, Dihydro-2(3H)-furanone, 1,2-Butanolide, 1,4-Butanolide; 4-Hydroxybutanoic acid lactone, gamma-hydroxybutyric acid lactone (Code of Federal Regulations 21 Part 1310.02 (a)) – Industrial Use Only – Not for human consumption

2. Name of Prospective Licensee: _____

   Address: _____

   _____

   Telephone: _____

3. All trade or business names: _____

4. Contact person(s) for the handling, storage or recordkeeping of controlled substances (attach additional pages if necessary):

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
_____	_____
Telephone	Telephone

5. Type of ownership:

   □ Individual/Sole Proprietorship

   Name _____

   Address _____

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☐ Partnership: (Attach additional pages if necessary)

_____
Name of Partnership

_____ _____
Name of Partner Name of Partner

_____ _____
Address of Partner Address of Partner

☐ Limited Liability Company: (Attach additional pages if necessary)

_____
Name of LLC

_____ _____
Name of Manager or Member Name of Manager or Member

_____ _____
Address of Manager or Member Address of Manager or Member

_____

☐ Corporation

_____
Name of Corporation

_____
State of Incorporation

Name and title of each corporate officer and director: (Attach additional pages if necessary)

_____ _____
Name Name

_____ _____
Title Title

_____ _____
Name Name

_____ _____
Title Title

_____ _____
Name Name

_____ _____
Title Title

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6. Describe the business, the physical facilities, and the type security provided. (Attach additional pages if necessary)

_____

_____

_____

7. DEA number of licensee: _____ Expiration date _____

8. Has applicant or any partner, officer, director or agent ever been convicted of a misdemeanor involving any controlled substance?

☐ Yes (attach explanation) ☐ No

9. Has any applicant or any partner, officer, director, or agent been convicted of any felony?

☐ Yes (attach explanation) ☐ No

Changes in the above information must be submitted on form DCB 11 within 30 days or at the time of renewal, whichever occurs first.

I understand that the Cabinet for Health Services shall be notified in the event of any theft or other loss of controlled substances. Any problem, such as pilferage, which develops in a facility, must also be reported. Assistance may be available if desired.

I hereby certify that all answers given in this application are true, complete and correct and I understand that any license issued to me by the Cabinet for Health Services may be suspended or revoked for cause.

_____

Printed Name & Title of Applicant

_____ _____

Signature Date

FOR OFFICE USE ONLY

Date application received _____ Date Fee Received _____